March 26, 2001

Dear Dr. Trujillo;

In FY 2000 and FY 2001, the Federal Disparity Index (FDI) workgroup, originally named the Level of Need Funded workgroup, developed a methodology for measuring gaps in health care funding to Indian people. The study found that Indian Health Service (IHS) funding was less than 60 percent of actuarially priced coverage if American Indians and Alaska Natives (AI/AN) were covered in the Federal Employees Health Benefit Plan. The workgroup also recommended a formula for distributing the Indian Health Care Improvement Fund (IHCIF) to tribes based on specifications contained in section 1621(a)4 of the Indian Health Care Improvement Act which requires the IHS to address deficiencies for "…those Indian tribes with the highest levels of health status and resource deficiencies."

In fiscal year 2001, the Indian Health Service (IHS) conducted extensive tribal consultation, including three regional forums and a national forum, on the IHCIF allocation methodology. After additional consultation with tribal leaders, in April 2001 you adopted an IHCIF formula that distributed $40 million on a recurring basis to local operating units.

The FDI workgroup recently met March 19 and 20, 2002 to accomplish an annual review of the IHCIF allocation methodology applied with updated data. After reviewing the IHCIF formula and considering its application with revised data, *the workgroup reaffirmed with no substantive changes the IHCIF formula adopted in FY 2001 after extensive tribal consultation*.

Before summarizing our recommendations, it is appropriate to briefly review the history of the equity issue as a means of placing in context our recommendations concerning the FY 2002 Indian Health Care Improvement Fund (IHCIF).

BACKGROUND

The provision of a broad scope of health and public health services to the American Indian and Alaska Native (AI/AN) Tribes is a continuing responsibility of the U.S. government. Historically, these services have been provided through annual discretionary funding provided to the IHS. Over the past thirty years there has developed a chronic pattern of under funding. In recent years, the Congress has failed to provide sufficient funds to address even natural population growth and medical inflation. The resulting erosion of buying power has contributed to the disparity in health status among AI/AN communities.

In 1992 the Congress attempted to address this situation through the enactment of Section 1621 of the Indian Health Care Improvement Act, which authorized the IHCIF for "eliminating the deficiencies in health status and resources of all Indian tribes". Sadly no funds were appropriated to the IHCIF until eight years later. In December 1998 you created the LNF Workgroup and assigned to us the responsibility to develop a methodology to identify the health status and resource deficiency for each tribe as required in the Act.

In developing the methodology, the Workgroup has tried to uphold core principles of comparability and credibility based on objective data. Fundamentally, the FDI methodology makes an "apples to apples" comparison between the cost of service provided to the IHS active users and the cost of services provided by the Federal Employees Health Benefit Package, a mainstream health plan available to federal employees through out the nation. This comparison addresses personnel health care services, the core activity of the agency, but not the full scope of IHS services which include critical public health, environmental, and community sanitation programs. The approach we selected is based on an actuarial analysis of the IHS active user population that seeks to identify health care funding for AI/AN that is comparable to other Americans of similar age and health characteristics.

REVISED AND UPDATED DATA

The most important change in the FY 2002 IHCIF allocation formula is the use of more recent data. A message universally expressed during LNF consultations last year was concern about dated and inaccurate data. We understand the IHS has worked to improve user counts for FY 2001 and to revise the national tabulation process to more accurately exclude individuals with duplicate records. We understand there is continuing concern about the user counts issued by the IHS on March 1, 2002, especially regarding adequate time for tribal consultation. After reviewing the FY 2001 user counts, we conclude they are more recent and more accurate than FY 1998 user counts and should be used in the IHCIF allocation formula. Below is a list of updated data elements that we recommend for use in the IHCIF formula. In the last section of this paper, we offer additional recommendations to improve data.

- FY 2001 User Count – The IHS user definition counts members of federally recognized tribes residing in a Contract Health Service Delivery Area (CHSDA) who visited an IHS or tribal health care program at least once during a three year period from October 1999 through September 2001. Applying this definition, the updated user count as of September 30, 2001 is 1,346,520. We understand that the apparent reduction of 55,000 users compared to FY 1998 is not, in fact, fewer real persons. Rather, more accurate tabulations eliminated substantial duplication in 1998 counts. As a result, the total IHS user count is approximately 3% less than the artificially elevated 1998 user counts. It is important to keep in mind that user counts for the 244 operating units were individually variable, e.g., some operating unit counts decreased by more than 10%, some increased by more than 10%, and still others remained essentially unchanged. Relative differences in FY 2002 operating unit allocations compared to FY 2001 operating unit allocations are due in large part to revised user counts (FY 2002 operating unit allocations are less in general because only $23 million is available in FY 2002 compared to $40 million in FY 2001).
- User Add-On from Non-CHSDA areas – Consistent with our recommendations last year, we add counts in the IHCIF formula for users who met all criteria in the user definition except residing within boundaries of a IHS CHSDA. This adds an additional 39,342 users for a total count of 1,385,862 for purposes of the IHCIF allocation formula.
- 11.2% Medical Inflation – The benchmark price per user for a personal health care benefits package was $3,221 in 2000. For FY 2001, we have inflated the price benchmark by 11.2%,

which is the overall percentage increase for employer sponsored health plans reported in a large national survey (Mercer Foster Higgins). The revised price benchmark is $3,582 per user, an increase of $361 compared to FY 2000. This single factor – 11.2% inflation for medical care in FY 2001 – has increased the cost to fully fund a mainstream benefits package for IHS users to $4.96 billion, an increase of $500 million over the FY 2000 estimate.

- No New Data on Other Coverage – Our estimate of health care payments for AI/AN by other sources remains at 25% of total cost of the benefits package, e.g., $895 per user in 2001. Discounting the $3,582 price benchmark by $895 gives a net price of $2,687 per user and results in a net benefits package cost to IHS of $3.72 billion.
- Updated Health Status Data – We have revised the health status factors in the model to reflect more recent data provided by the IHS Office of Program Statistics. The health status indicators are used to adjust for cost variations resulting from differing health conditions of the user population residing in each IHS Area.
- Updated IHS Available Resources – IHS Area Offices have updated a detailed line-item accounting of all IHS funds distributed to operating units in FY 2001. Total IHS funding in FY 2001 was approximately $330 million more than in FY 2000. Consistent with our methodology last year, we have discounted available resources to the extent the funds were used for purposes not in the benchmark personal health care benefits package, i.e., wrap-around items such as sanitation facilities and public health functions.
- Geographic Price Variations are Unchanged – Geographic variations in medical price indices are substantially stable year-to-year. No changes were made to this factor this year. Similarly, the workgroup granted price adjustments for high costs of remoteness and harsh climate that were documented for Alaska operating units in FY 2000. The Alaska price adjustments and exclusions were revised to reflect documented costs in FY 2001.
- Variations in Operating Unit Cost – The methodology adjusts the benchmark price among operating units for differences in economies of scale (unit prices for small operating units are adjusted higher compared to large operating units). No changes were made to this computation for FY 2001, although modest changes for individual operating units result from updated user counts.
- Poverty Data are Unchanged – No new data on the percentage of AI/AN below the poverty line were available this year. These data are unchanged in the FY 2002 formula.

REAFFIRMED THE IHCIF RESOURCE ALLOCATION FORMULA

Applying FY 2001 data, the model estimated that $3.72 billion was needed by IHS to assure personal health care services to IHS active users that are comparable to those available to federal employees. The IHS expended $1.92 billion in FY 2001 for personal medical services – a funding ratio of 52% of need compared to 51% of need in FY 2000. The 1% net improvement in FY 2001 is a consequence of higher medical prices offset by a lower user count and increased appropriations to IHS. For the same time period, IHS expended $.78 billion for community sanitation projects, public health programs, and other services not covered in the benchmark personal health care benefits package. The model does not estimate needed resources for these "wrap-around" health programs.

The model provides a "snap-shot" in time of the needs and funding of the Indian health care system, .e.g., a recent fiscal year in which user counts and funding are fully identified for the 244 operating units of the Indian health system. We consider the following estimates applicable to a snap-shot ending September 30, 2001. These estimates do not consider additional population growth, additional medical inflation, or funding distributed to operating units after September 30, 2001.

- Personal health care benefits package price benchmark = $3,582 per user annually
- Cost to fully fund a benefits package for 1,385,000 users = $4.96 billion
- Price benchmark net of other coverage = $2,687 per user annually
- Balance of cost to IHS = $3.72 billion
- IHS expenditures for personal health care = $1.92 billion
- IHS personal health care expenditures per user = $1,384
- Personal health care benefits package funding percentage = 52%
  ($1,384 expenditures per user / $2,687 benchmark price per user)

  - 62 OUs less than 40% ($44 million shortfall)
  - 169 OUs less than 60% ($408 million shortfall, cumulative)
  - 219 OUs less than 80% ($1.1 billion shortfall, cumulative)
  - 229 OUs less than 100% ($1.8 billion shortfall, cumulative)
- IHS expenditures for "wrap-around" programs = $.78 billion
- "Wrap-around" expenditures per user = $568

After considering these results, *the workgroup reaffirmed with no substantive changes the IHCIF formula adopted by the IHS in FY 2001 after extensive tribal consultation*. The elements that we reaffirmed include:

1. The FY 2002 formula allocates the $23 million IHCIF to only those operating units that are funded at less than 60%. The results show that 169 operating units are below 60% and will qualify for a portion of the IHCIF. The $23 million available in FY 2002 provides only 5.6% of $408 million necessary to raise 169 operating units to 60%. Among the 169 operating units qualifying for IHCIF funds, the formula gives proportionately more funds to the least well funded operating units. Additionally, every operating unit is guaranteed funding to achieve at least 30%. This is consistent with the approach in FY 2001 and with Congressional direction to focus Indian Health Care Improvement funds to tribes that are "most in need".

2. The Congress urged consideration for a minimum allocation to operating units that qualify for IHCIF funds. The workgroup set a minimum allocation of $10,000 per operating unit last year. The $10,000 minimum is continued for FY 2002 allocations.

3. The workgroup reaffirmed that the $23 million FY 2002 IHCIF be allocated to local operating units and that such allocations be made recurring to the operating unit in years thereafter.

4. The workgroup reaffirmed the "IHCIF allowance guidance" provided by IHS headquarters to Area Offices acknowledging an opportunity for adjustments among Area operating units when determined with participation by Area tribes and Area operating units.

5. The Workgroup reaffirmed the need for review and improvement of the IHCIF formula on an annual basis. Members believe that a mid-year Workgroup meeting before the next allocation cycle would provide an opportunity for improving the methodology without the undue pressure of a "winners and losers" scorecard. Workgroup members re-elected Mr. James Crouch to continue as Tribal co-chair and urge you to retain Mr. Cliff Wiggins as Federal co-chair.

CONTINUING ISSUES OF CONCERN

There is a list of serious and in some cases long standing issues of concern that the workgroup identified last year and that the IHS did not fully resolve in 2001. We again urge the IHS to address these as quickly as possible. Although the Workgroup recognizes that the IHS has made considerable efforts in 2001 to improve data collection systems, especially for user counts, these efforts have yet to accomplish all their goals. Sufficient resources must be marshaled at all levels to overcome these problems.

A theme heard consistently in all three regional consultation meetings is the need for a rigorous data driven formula to identify funding needs for public health, outreach and environmental health services not addressed in the FDI methodology. We understand this "wrap-around" effort is now beginning. We urge you proceed expeditiously.

A significant portion of the tribal leaders who participated in the regional consultation meetings expressed opinions that the methodology should not include third party coverage available to Indian people including Medicaid, Medicare, private health insurance and the Children's Health Insurance Program (S-CHIP). This opinion is driven in part by a feeling that increased reliance on these funding sources represents a rollback of the federal trust responsibility to Indian Tribes. Another reason expressed is that access to health care for Indian people should not be subject to means testing. Inclusion of these resources in the FDI methodology, however, is responsive Congressional directives established in statute in Section 1621 of the Indian Health Care Improvement Act. The Workgroup urges that you communicate as forcefully as possible to the Administration the critical role that the IHS plays in providing access to heath services and coverage to the Indian community.

The Centers for Medicare/Medicaid Services (CMS) is the second largest funding source for health care services to the Indian community through its Medicaid, Medicare and S-CHIP programs. This activity has created a large body of encounter level data on health care services to AI/AN. Unfortunately there is a high level of misidentification of Indian Tribal status in this database. The IHS active user data set clearly identifies the Indian population that depends on the IHS as its primary health care provider. Matching these two data sets would provide the information to more fairly identify third party coverage by operating

unit. And, perhaps more importantly, it would provide the encounter level information necessary to update the cost benchmark for personal medical services. We understand the IHS has begun collaborating with CMS to share databases and match joint Medicare AI/AN beneficiaries. We also understand you have plans for similar statistical tabulations for matched Medicaid AI/AN joint beneficiaries. We urge you to complete this work.

We were briefed by telephone conference about a large CMS research project to investigate the extent and causes for gaps in AI/AN use and eligibility for CMS entitlements. Such information will be useful for some purposes, but we are disappointed that the study will not quantify the financial gap. We need this data to credibly update our cost benchmark to reflect meaningful differences in third party coverage among states, IHS Areas, and operating units. We believe this data is essential to promote real funding equity.

In the past several years, a significant number of tribes and health programs have responded to the lack of federal facility construction funding by entering into long-term debt to finance replacement of old and inadequate health care facilities. An extensive study done by the National Indian Health Board has documented the importance of this trend to the viability of the IHS funded health care delivery system. Servicing construction debt is generally accomplished through a long-term commitment of third party income, which would otherwise be available for the provision of health care services to tribal members. The task group recommends that the IHS develop a national database that would identify any health facility financing costs incurred by tribes so that any debt payments may be discounted from the FDI methodology.

The Workgroup again added counts of AI/AN who live outside of designated Contract Health Service Delivery Areas (CHSDA) and who regularly obtain direct care services in IHS and tribal health facilities though they are ineligible for referral under CHS. This approach rightly identifies the financial burden of providing care to these persons. Workgroup members remained concerned about the official IHS user definition and recommend that IHS fully explore legal, financial, and technical ramifications of revising the definition.

The Workgroup offers the following recommendations in recognition of the importance of timely, high quality data that is essential for determining accurate user counts and for many other worthwhile purposes:

- IHS should continue to improve methods for aggregation and tabulation of local user data into national user counts
- IHS and tribes must target additional resources to improve data collection and data quality in the front lines at operating units
- Additional funding is necessary for growing costs of broad band telecommunications links that are increasingly essential in everyday work at operating units
- Health system managers and tribal health leaders recognize that budget justification and accurate resource allocation depend on quality data (e.g., "funds follow data")
- The Workgroup endorses a Restructuring Initiative Workgroup proposal to invest in improved data collection and tabulation at local levels and for better collaboration among operating units

- The Workgroup recommends that the Business Plan Workgroup also address investment in data as a major strategy for the next 5 year business plan
- IHS and tribes should continuously seek a reasonable balance between the benefit of increased data precision and the financial investment in data that is necessary get that benefit

The workgroup acknowledges that Contract Support Costs (CSC) funds are discounted too heavily in the IHCIF allocation model. Many items commonly paid from CSC funds are typical business costs experienced by any mainstream health plan. These costs are financed within the plan's premium structure and, therefore, are included in our actuarially determined benchmark price of $3,582 per beneficiary. The workgroup agreed to discount CSC by 62% to assure that the IHCIF allocation formula is not unfairly biased against tribal contracts. We thought this was necessary because CSC is "on-budget" whereas some expenditures benefiting federal operating units for similar items are "off-budget". The extent of "off-budget" expenditures benefiting federal operating units is unknown at this time. Thus, we exclude "off-budget" federal expenses and 62% of available CSC resources from the personal health care services computation, although both would be more appropriately included in our computation if reliably known. The excluded CSC funds are counted as part of wrap-around total instead. This exclusion artificially lowers available funding for the benefits package by approximately 3-5% depending on the true extent of "off-budget" federal costs. We urge the IHS in the coming year to determine the extent of "off-budget" expenses so that we may appropriately count both those resources and CSC resources in the IHCIF methodology.

The FDI methodology is an actuarial based method of resource planning and distribution. It relies on techniques long used by both private industry and other governmental programs to calculate resource requirements. The Workgroup recommends that the IHS further integrate the approach into its budget development and justification activities. The identification of a $1.8 billion shortfall in IHS funding for personal health care services for fiscal year FY 2001 is solid evidence of a historic under funding of health care for Indian people.

As co-chairs, we thank you on behalf of all Workgroup members for supporting our work and we look forward to hearing your decisions regarding a distribution of the $23 million IHCIF.

James Allen Crouch M.P.H.

Cliff Wiggins, IHS Co-Chair

Enclosures